STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046057	A. BUILDING _____ B. WING _____	C 11/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 WEST 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS 60475 and KS 61125.	S 000		
S3026 SS=E	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: The facility documented a census of 41 residents. The sample included 5 residents. Based on observation, record review and interview, the facility failed to maintain a system to monitor residents for 4 of 4 residents (#1, #3, #4, #5) at risk for elopement. Findings included: - Resident #1's Negotiated Service Agreement dated 5/4/12 under health care services included to monitor the resident for wandering related to a new environment. The Resident Functional Capacity Screen dated 5/3/12 included wandering as a current problem, had short term problems, and memory recall and decision making problems.	S3026		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S3026	Continued From page 1 Fall Risk Assessment dated 5/3/12 scored 14, 7/12/12 scored 14, and 9/17/12 scored 24 (total score of 10 or above represented High Risk for falls). Elopement Precautions date 5/3/12 scored 13 (score 4 or greater represented High Risk for elopement). The care plan dated 5/4/12 included wanderguard/pendant alert watch. On 9/17/12 the updated care plan included change the wanderguard/pendant to a neck type rather than wrist. Staff should monitor the resident every 2 hours when no caregiver was present with the resident. Review of the clinical record on 9/16/12 at 6:30 P.M. revealed the front desk independent living unit receptionist called the assisted living unit and reported resident #1 had fallen down outside on the hill. Licensed nursing staff A walked over to the independent living unit from the assisted living unit past the motion detector light and then outside the front entrance door, down the sidewalk and then down the hillside to find the resident laying on his back. The resident's walker had been picked up by the receptionist and placed near the resident. The resident's shoes were both off, laying on the hillside. The resident told the assisted living staff that he/she had to go home. The staff assisted the resident into an upright position and walked him/her back into the facility. On 11/1/12 at 7:45 A.M. licensed nursing staff A revealed the resident did have a wanderguard on. On 11/1/12 at 12:42 P.M. maintenance staff D revealed that the assisted living had no magnetic	S3026		

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S3026	Continued From page 2	S3026		

locks for the wanderguards. Maintenance staff D revealed that the facility did not check the wanderguard system. Maintenance staff D revealed when a resident with a wanderguard got near the motion detector outside the men's bathroom, the Tag ID display would show which resident was there. The information would go to the computer at the nurses' station and to all the staff pagers. The resident had to go through the doorway that led off the assisted living unit into the independent living unit for the system to go off. Maintenance staff D revealed he/she was able to look back in the computer system to see if the alarm went off when the resident went through the doorway. Maintenance staff D revealed he/she was unable to find any entry showing the resident had went through the doorway.

On 11/1/12 at 8:20 A.M. observation revealed the resident at the dining room table eating breakfast and no visible wanderguard on the resident.

On 11/1/12 at 10:15 A.M. observed the resident dozing in a recliner with a sitter in the room. The sitter revealed that the resident had a call pendant in the bedroom to call the staff as needed. The sitter was unable to find a wanderguard on the resident and no wanderguard on the resident's walker. The sitter got a call pendant from the resident's bedroom and observed a wanderguard attached to the call pendant.

On 11/1/12 at 12:30 P.M. the resident sat in the dining room and finished lunch. The resident walked back to the elevator with the sitter and had a wanderguard present on his/her right wrist.

On 11/1/12 at 12:30 P.M. direct care staff H

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S3026	Continued From page 3 revealed the staff should check to make sure the wanderguards were on the residents. The facility did not have a check system for the staff to follow. He/she stated the staff did not check that the resident had the wanderguard in place and whether the wanderguard was in working condition. On 11/1/12 at 12:46 P.M. licensed nursing staff A revealed the 4 residents with wanderguards had lived on the independent living unit. The facility decided they needed more assistance as the resident had left the independent living unit and no one knew where the resident had gone so the facility moved the wandering residents over to the assisted unit. The facility staff should make sure each resident that was suppose to have a wanderguard on, did have the wanderguard on. All the staff should check the residents to be sure the wanderguards were in place. On 11/2/12 at 7:55 A.M. direct care staff I revealed that he/she had not checked the wanderguards before the new sheets for monitoring came out yesterday. On 11/2/12 at 7:58 A.M. direct care staff J revealed he/she did not check the residents for the wanderguards before the new monitoring sheets came out yesterday. The revised 11/06 facility policy "Suggested Interventions for Wandering Behavior" instructed the staff to check on wanderers' whereabouts regularly. The facility to utilize a selective electronic system that will alarm when an identified resident walked further than a defined distance or when the individual attempted to exit the facility.	S3026		

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S3026	Continued From page 4 The facility failed to have a system in place to monitor this cognitively impaired resident at risk for falls and elopement that eloped from the facility, from eloping from the facility, - Resident #4's Negotiated Service Agreement dated 2/9/12 did not address behavior management related to wandering. The Functional Capacity Screen dated 2/8/12 did not include wandering risks. The Assisted Living Health Care Service Plan updated on 4/25/12 included staff had placed a wanderguard on the resident. The resident was aware that he/she needed to wear the wanderguard all the time for his/her safety. On 11/1/12 at 12:20 P.M. the resident sat at the dining room table and no wanderguard observed. On 11/1/12 at 5:00 P.M. the resident sat at the dining room table with his/her spouse and no wanderguard seen. On 11/2/12 at 2:00 P.M. the resident rested in bed with spouse and no wanderguard seen. On 11/2/12 at 5:10 P.M. the resident still did not have a wanderguard on. Licensed nursing staff B applied a wanderguard to the resident's right forearm at this time in the dining room. On 11/1/12 at 12:30 P.M. direct care staff H revealed the staff should check to make sure the wanderguards were on the residents. The facility did not have a check system for the staff to follow. He/she stated staff did not check that the resident had the wanderguard in place.	S3026		

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S3026	Continued From page 5 On 11/1/12 at 12:42 P.M. maintenance staff D revealed that the assisted living did not have magnetic locks for the wanderguards. Maintenance staff D revealed that the facility did not check the wanderguard system. Maintenance staff D revealed when a resident with a wanderguard got near the motion detector outside the men's bathroom, the Tag ID display would show which resident was there. The information would go to the computer at the nurses' station and to all the staff pagers. The resident had to go through the doorway that led off the assisted living unit into the independent living unit for the system to go off. On 11/1/12 at 12:46 P.M. licensed nursing staff A revealed the 4 residents with wanderguards had lived on the independent living unit. The facility decided they needed more assistance as the resident had left the independent unit and no one knew where the resident had gone so the facility moved the residents that wandered to the assisted unit. The facility staff should make sure each resident that was suppose to have a wanderguard on, did have the wanderguard on. All the staff should check the resident to be sure the wanderguard was in place. On 11/2/12 at 7:55 A.M. direct care staff I revealed that he/she had not checked the wanderguards before the new sheets for monitoring came out yesterday. On 11/2/12 at 7:58 A.M. direct care staff J revealed he/she did not check the residents for the wanderguards before the new monitoring sheets came out yesterday. The revised 11/06 facility policy "Suggested	S3026		

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S3026	Continued From page 6 Interventions for Wandering Behavior" instructed the staff to check on wanderers' whereabouts regularly. The facility will utilize a selective electronic system that will alarm when an identified resident walked further than a defined distance or when the individual attempted to exit the facility. The facility failed to have a system in place to monitor this resident at risk for elopement. - Resident #5's Negotiated Service Agreement dated 4/5/12 revealed no behavior management. Licensed nursing staff C was unable to find the Functional Capacity screen on 11/6/12 at 9:30 A.M. The Assisted Living Health Care Service Plan updated on 9/23/12 included staff placed a wanderguard on the resident and staff to monitor frequently to make sure he/she was wearing the wanderguard. On 11/1/12 at 12:20 P.M. the resident sat at the dining room table and no wanderguard observed. On 11/1/12 at 2:30 P.M. the resident watching TV in his/her room and no wanderguard present. On 11/2/12 at 7:45 A.M. the resident sat at the dining room table and a wanderguard was observed on his/her right wrist. On 11/1/12 at 12:30 P.M. direct care staff H revealed the staff should check to make sure the wanderguards were on the residents. The facility did not have a check system for the staff to follow. He/she said staff did not check the	S3026		

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S3026	Continued From page 7 residents if they had the wanderguard in place. On 11/1/12 at 12:42 P.M. maintenance staff D revealed that the assisted living had no magnetic locks for the wanderguards. Maintenance staff D revealed that the facility did not check the wanderguard system. Maintenance staff D revealed when a resident with a wanderguard got near the motion detector outside the men's bathroom, the Tag ID display would show which resident was there. The information would go to the computer at the nurses' station and to all the staff pagers. The resident had to go through the doorway that led off the assisted living unit into the independent living unit for the system to go off. On 11/1/12 at 12:46 P.M. licensed nursing staff A revealed the 4 residents with wanderguards had lived on the independent living unit. The facility decided they needed more assistance as the resident had left the independent unit so the facility moved the residents that wandered to the assisted living unit. The facility staff should make sure each resident that was suppose to have a wanderguard on, did have the wanderguard on. All the staff should check the resident to be sure the wanderguard was in place. On 11/2/12 at 7:55 A.M. direct care staff I revealed that he/she had not checked the wanderguards before the new sheets for monitoring came out yesterday. On 11/2/12 at 7:58 A.M. direct care staff J revealed he/she did not check the residents for the wanderguards before the new monitoring sheets came out yesterday. The revised 11/06 facility policy "Suggested	S3026		

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S3026	Continued From page 8 Interventions for Wandering Behavior" instructed the staff to check on wanderers' whereabouts regularly. The facility should utilize a selective electronic system that would alarm when an identified resident walked further than a defined distance or when the individual attempted to exit the facility. The facility failed to have a system in place to monitor this resident at risk for elopement. - Resident #3 Negotiated Service Agreement dated 1/17/12 lacked information related to wandering and/or elopement. The Resident Functional Capacity Screen dated 1/15/12 did not indicate the resident had wandering problems. Elopement precautions dated 1/15/12 scored 7 (score 4 or greater represented High Risk) for elopement. The care plan dated 1/15/12 lacked any information related to wanderguard and/or elopement. The nurses notes dated 3/25/12 at 4:10 P.M. documented the activity staff stopped the resident who attempted to exit from the facility. The resident returned to the assisted living unit and monitored hourly for safety. On 11/1/12 at 12:46 P.M. licensed nursing staff A revealed this resident had a wanderguard. On 11/1/12 at 11:20 P.M. the resident sat in the dining room and a wanderguard noted on the resident's left forearm.	S3026		

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S3026	Continued From page 9 On 11/1/12 at 12:30 P.M. direct care staff H revealed the staff should check to make sure the wanderguards were on the residents. The facility did not have a check system for the staff to follow. He/she said staff did not check that the resident had the wanderguard in place. On 11/1/12 at 12:42 P.M. maintenance staff D revealed that the assisted living had no magnetic locks for the wanderguards. Maintenance staff D revealed that the facility did not check the wanderguard system. Maintenance staff D revealed when a resident with a wanderguard got near the motion detector outside the men's bathroom, the Tag ID display would show which resident was there. The information would go to the computer at the nurses' station and to all the staff pagers. The resident had to go through the doorway that led off the assisted living unit into the independent living unit for the system to go off. On 11/1/12 at 12:46 P.M. licensed nursing staff A revealed the 4 residents with wanderguards had lived on the independent living unit. The facility decided they needed more assistance as the resident had left the independent unit and no one knew where the resident had gone so the facility moved the wandering residents to the assisted living unit. The facility staff should make sure each resident that should have a wanderguard on, did have the wanderguard on. All the staff should check the residents to be sure the wanderguard was in place. On 11/2/12 at 7:55 A.M. direct care staff I revealed that he/she had not checked the wanderguards before the new sheets for monitoring came out yesterday.	S3026		

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S3026	Continued From page 10 On 11/2/12 at 7:58 A.M. direct care staff J revealed he/she did not check the residents for the wanderguards before the new monitoring sheets came out yesterday. The revised 11/06 facility policy "Suggested Interventions for Wandering Behavior" instructed the staff to check on wanderers' whereabouts regularly. The facility to utilize a selective electronic system that would alarm when an identified resident walked further than a defined distance or when the individual attempted to exit the facility. The facility failed to have a system in place to monitor this resident at risk for elopement.	S3026		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: The facility documented a census of 41 residents. The sample included 5 residents. Based on observation, record review and interview, the facility failed to meet the needs of 1 of 5 residents (#2) in accordance with the functional capacity screening and the negotiated service agreement. Findings included:	S3155		

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S3155	Continued From page 11 - Resident #2's Negotiated Service Agreement dated 3/26/12 included fall prevention. The Health Care Service Plan dated 3/26/12 included the following skilled nursing procedures for fall prevention: 6/16/12 - Resident advised to eat 3 meals if going to consume alcohol. 6/16/12 - Staff to check on resident after supper meal every night and assist resident if needed. 7/2/12 - Place bars (for grabbing) next to shower. Completed 7/2/12 at 10:30 A.M. 8/27/12 - When son visited, the resident needed checked frequently related to excessive drinking. 9/8/12 - Staff to attempt to monitor alcohol consumption- resident stated only had 1 per day. When family was not here we can believe that this is fairly true. (dc 10/16/12) 9/12/12 - no rugs on floor unless showering. 9/29/12 - Staff to remain with resident when showering. Resident loses his/her balance easily. Resident most of the time was resistive to staff assistance though. 10/16/12 - No new medication orders - resume current care before hospitalization - no loss of consciousness. 10/16/12 - Outside agency hired to stay with resident when family not present until resident more stable. Family will discuss with facility director times of care giving from agency. Night/evening caregivers to resume care when family not present. The Fall Risk assessment done on 3/26/12 scored 18 which indicates a total score of 10 or above represented the resident as a high risk for falls. The facility completed the fall risk assessment after every fall which included the following with score:	S3155		

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S3155	Continued From page 12 3/30/12 - 18 5/19/12 - 20 6/16 - 20 9/12 - 24 9/28 - 25 9/29 - 25 10/9 - 25 10/14 - 25 The clinical record revealed the following nurses notes related to falls: 3/30/12 at 7:24 P.M. non injury fall. 5/19/12 at 2:30 A.M. the resident called for assistance and the staff found the resident sitting on the bathroom floor, non injury fall. 6/16/12 at 7:00 P.M. staff found the resident lying in the shower, skin tears left elbow. 6/30/12 at 6:15 P.M. staff found the resident on the floor with a skin tear to the right arm. The family took the resident to the hospital. 8/27/12 at 7:00 P.M. staff found the resident on the floor. 8/27/12 at 8:05 P.M. sibling notified the staff the resident had fallen again and obtained a skin tear to his/her right knee. 9/8/12 at 7:00 P.M. staff found the resident on his/her floor with bruising to the resident's inner right arm and abrasion to elbow. 9/9/12 at 7:00 P.M. staff found the resident lying on his/her back on the floor in the bathroom with a skin tear to the right elbow. 9/12/12 at 7:00 P.M. staff answered a call light	S3155		

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S3155	Continued From page 13	S3155		

and the resident fell while trying to leave the apartment. Staff found the resident on the floor behind the door and his/her right arm and elbow were bleeding.

9/28/12 at 8:45 A.M. staff found the resident sitting on the floor outside his/her apartment.

9/29/12 at 2:00 P.M. staff assisted the resident with a shower. The staff left the bathroom to get the resident's socks. The resident fell backwards and obtained a skin tear to his/her left hand and left elbow.

10/9/12 at 2:00 P.M. staff found the resident sitting upright on the floor in the doorway between the bedroom and the living room. The resident said he/she tripped over the wheel of the walker.

10/14/12 at 7:30 A.M. staff found the resident on the floor lying on his/her back beside the bed with his/her head resting on a pillow. There was blood on the pillow, the phone, and in the shower. The resident received a laceration above his/her right eye, skin tears on both arms, and a large hematoma to his/her right eye. The resident was admitted to the hospital for stitches to his/her forehead and a fractured rib.

On 11/1/12 at 8:20 A.M. the resident sat in the dining room eating breakfast, scabbed area noted over right eye and bandage on left hand.

On 11/1/12 at 9:00 A.M. the resident's care giver came. The resident walked with a roller walker and steady gait back to his/her room.

On 11/1/12 at 7:45 A.M. licensed nursing staff A revealed that he/she was working on 10/14/12. The staff went to the resident's room to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046057	A. BUILDING _____ B. WING _____	C 11/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 WEST 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3155	Continued From page 14 him/her up for breakfast and found him/her lying on the floor and there was dried blood everywhere. The resident was lying on the floor next to his/her bed with a pillow covered with blood under his/her head. He/she had cut on his/her head. There was dried blood on the floor from the bathroom to his/her bed. On 11/2/12 at 12:50 P.M. direct care staff E revealed the night shift only checked on the resident if the resident called for assistance. On 11/2/12 at 12:55 P.M. licensed nursing staff G revealed the night shift staff did not check on the residents unless the staff knows the resident needed extra assistance. The staff also answered lights when the resident called for assistance. The revised 2/08 facility policy "Falls" instructed the staff to document on the overall plan of care appropriate interventions to minimize falls. The clinical record lacked evidence the facility assessed and provided interventions after the falls on 3/30/12, 5/19/12, 6/30/12, 9/9/12,9/28/12, and 10/9/12. The facility failed to assess and provide timely and effective interventions for this resident with a history of falls to prevent further falls resulting in a laceration and fracture.	S3155		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.	S3320		

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S3320	Continued From page 15 (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: K.A.R.28-39-254(a) The facility documented a census of 41 residents. The sample included 5 residents. Based on observation, record review and interview, the facility failed to maintain a safe environment for 11 cognitively impaired independently mobile residents. Findings included: - On 11/1/12 at 7:45 A.M. licensed nursing staff A provided a tour of the facility of the assumed route that a resident had used previously when he/she left the building. The hallway to the independent living had several unlocked doors. The first unlocked door to the left on the west hallway led into the kitchenette area that	S3320		

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S3320	Continued From page 16 contained a steam table that was on and no staff present. The first unlocked door to the right led to 2 unmanned elevators and also the main kitchen. The next unlocked open door lead into a room with exercise equipment and contained another unlocked door that opened up into a pool room with 3-5 feet of heated, chemically treated water. 11/1/12 at 12:42 P.M. Maintenance staff D revealed the pool door was never locked unless the staff were treating the pool with chemicals. Staff should keep the kitchenette door locked. The door to the elevators was never locked and the main kitchen door was locked only after the staff all left at the end of the day. 11/1/12 at 12:46 P.M. Licensed nursing staff A revealed he/she had never seen the kitchenette door, the exercise room door, the elevator door or the pool room door locked. On 11/6/12 at 3:30 P.M. administrative staff K revealed the assisted living unit housed 11 cognitively impaired independently mobile residents. The assisted unit also housed 4 residents that required wanderguards due to history of elopement. The facility was unable to provide a policy related to the locking of doors leading into potential hazardous areas. The facility failed to maintain and protect the health and safety of cognitively impaired mobile residents related to unlocked, open doors to hazardous areas.	S3320		